

**SOUTHWEST ORTHOPEDIC  
GROUP, LLP**

DATE: \_\_\_\_\_

DR. NAME: \_\_\_\_\_

**PATIENT DATA**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ MALE OR FEMALE \_\_\_\_\_ Marital Status: M S W D  
Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
Occupation: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
Referred By: \_\_\_\_\_ OFFICE NO.: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

NAME \_\_\_\_\_ PHONE NO.: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

**EMPLOYER INFORMATION:**

EMPLOYER NAME \_\_\_\_\_ PHONE NO.: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**GUARANTORS INFORMATION:**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Patient's Relationship to Policy Holder: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:**

Name of Primary Insurance \_\_\_\_\_ Customer Service No: \_\_\_\_\_  
ID NUMBER \_\_\_\_\_ GROUP NO. \_\_\_\_\_

**SECONDARY INSURANCE:**

Name of Secondary Insurance \_\_\_\_\_ Customer Service No: \_\_\_\_\_  
ID NUMBER \_\_\_\_\_ GROUP NO. \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS OF PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.**

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**GERARD T. GABEL, M.D.**  
**CIRUJANO ESPECIALISTA EN MANOS, HOMBROS, Y CODOS**  
**DEPARTAMENTO DE CIRUGÍA ORTOPEDICO**  
**(POR FAVOR LLENE COMPLETAMENTE ESTA HOJA INCLUYENDO LA**  
**PARTE DE ATRAS)**

FECHA \_\_\_/\_\_\_/\_\_\_ NOMBRE\_\_\_\_\_

EDAD\_\_\_\_\_ QUIÉN LO REFIRIO?\_\_\_\_\_

OCUPACIÓN\_\_\_\_\_ ESTADO MARITAL: S C D V

¿Derecho tú: DERECHO\_\_\_\_\_ IZQUIERDO\_\_\_\_\_

¿Dónde está tú dolor? Dolor de cuello\_\_\_\_\_

Derecho: Hombro\_\_\_ Codo\_\_\_ Antebrazo\_\_\_ Muñeca\_\_\_ Mano\_\_\_ Dedo\_\_\_

Izquierdo: Hombro\_\_\_ Codo\_\_\_ Antebrazo\_\_\_ Muñeca\_\_\_ Mano\_\_\_ Dedo\_\_\_

¿Cuándo empezaron tus síntomas? \_\_\_/\_\_\_/\_\_\_ ¿ Cuales son tus síntomas?\_\_\_\_\_

¿Si tú síntomas son resultado de un accidente, dónde y qué día ocurrió el accidente?

¿Dónde?: Casa\_\_\_ Escuela\_\_\_ Trabajo\_\_\_ Automóvil\_\_\_ Fecha: \_\_\_/\_\_\_/\_\_\_

¿Qué paso?\_\_\_\_\_

¿Dónde trabajas?\_\_\_\_\_

¿Si estas empleado, cuánto tiempo tienes en tu trabajo?\_\_\_\_\_

¿En algun trabajo anterior tuviste algun accidente?\_\_\_\_\_

Describe:\_\_\_\_\_

¿Si fue otro trabajo, ultimo dia de trabajo? \_\_\_/\_\_\_/\_\_\_.

Presente trabajo restricciones:\_\_\_\_\_

¿Esta envuelto algun abogado? Si\_\_\_ No\_\_\_

Nombre\_\_\_\_\_. Telefono: ( ) \_\_\_-\_\_\_\_\_.

¿Qué tratamiento(s) has tenido para este problema (Inyecciones, medicinas, cirugías, terapia etc..)? \_\_\_\_\_

¿Qué exámenes te practicaron para diagnosticar tu problema?\_\_\_\_\_

**SIGUE ATRAS**

## HISTORIA CLINICA DEL PACIENTE

	<b>Usted</b>	<b>Familia</b>		<b>Usted</b>	<b>Familia</b>
Diabetes	_____	_____	Problemas de pulmon	_____	_____
Problemas del corazon	_____	_____	Transfusión	_____	_____
Reumatoide	_____	_____	Lupus	_____	_____
Artritis	_____	_____	Tuberculosis	_____	_____
Problemas de tiroides	_____	_____	Hernia	_____	_____
Asma	_____	_____	Problemas de la mente	_____	_____
Coagulo	_____	_____	Corazon	_____	_____
Cancer	_____	_____		_____	_____
Pulmonia	_____	_____	Colitis	_____	_____
Problemas de sangramiento	_____	_____	Abuso de alcohol	_____	_____
Sida	_____	_____	La Presion alta	_____	_____
H.I.V	_____	_____	Hepatitis	_____	_____
			HIV/AIDS	_____	_____

La Ultimata regla: \_\_\_\_\_

Embrazada? Si No

Fuma? Si No Si fumas, cuantos paquetes al dia? \_\_\_\_\_

Tienes algunos pasatiempos que usas su mano(s) o brazo(s)

Si \_\_\_\_\_ No \_\_\_\_\_ Si es sí, cuales son? \_\_\_\_\_

Le duelen las artibciones? Si, cual \_\_\_\_\_

\_\_\_\_\_

Por favor apunta todas las medicinas que de da reaccion alergica: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Por favor apunta todas las medicinas que usted esta tomando incluyendo sin recetas: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Por favor apunta todas sus cirugias: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# ***SOUTHWEST ORTHOPEDIC GROUP, LLP***

## **Review of Notice of Privacy Practices**

### **Acknowledgement:**

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
**Patient or Personal Representative  
Signature**

\_\_\_\_\_  
**Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: \_\_\_\_\_.

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## **Financial Policy Statement**

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

\_\_\_\_\_  
**Patient or Responsible Party**

\_\_\_\_\_  
**Date**